DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	446008	A. BUILDING _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BARNABAS NURSING HOME	950 SISKIN DRIVE CHATTANOOGA, TN 37403

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F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete a restraint assessment and attempt restraint reduction for one resident (#48) of thirty residents reviewed. The findings included: Resident #48 was admitted to the facility on January 10, 2007, with diagnoses including Hypothyroidism, Hypertension, Dysphagia, and Failure to Thrive. Medical record review of the Annual Minimum Data Set dated August 18, 2013, revealed the resident had severely impaired cognitive skills for daily decision making and used a trunk restraint daily. Medical record review of the Physical Restraint Reduction Assessment dated August 18, 2013, revealed "Instructions: Restrained individuals should be reviewed at least quarterly to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination. For each category listed below, assess the resident by circling the corresponding score(s) that best describe his/her current status in the appropriate assessment	F 221	**Facility Disclaimer:** **This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **F 221** 1) A Restraint Reduction Assessment was completed on resident #48 by the MDS nurse on 9/13/13. A therapy screen was completed by the Physical Therapist on 9/12/13 for a less restrictive devise. The therapy screen found that at this time, 9/13/13, by the Physical Therapist to be the safest and least restrictive intervention for this resident for continued safety awareness and to decrease the potential for falls. 2) This facility will institute the following systematic changes: Residents requiring restraints must be approved by the Director of Nursing or designee and the falls interdisciplinary team (DON, ADON, Therapy services, Social Services staff, MDS nurses). Restraint reduction assessments will be completed by the MDS nurse at the time of the next quarterly	10/17/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 10/16/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 column. Add the column of numbers to obtain the total score. Continue evaluation and review on the reverse..." Medical record review of the Physical Restraint Reduction Assessment dated August 18, 2013, revealed the resident scored a 25 (21-35 Good Candidate). Medical record review of the reverse side of the Physical Restraint Reduction Assessment revealed no documentation of the continued evaluation and review of the restraint assessment on August 18, 2013. Medical record review of a Physician's order dated August 23, 2013, revealed "...soft self release velcro belt while up in chair...check restraint and release per facility protocol..." Observation and interview on September 10, 2013, at 7:45 a.m., with Licensed Practical Nurse (LPN) #3, in front of the nursing station, revealed the resident seated in a tilt/recline chair, with a soft velcro seat belt in place. Continued observation revealed the resident was unable to self release the seat belt when asked by LPN #3. Observation on September 11, 2013, at 7:45 a.m., revealed the resident seated in the chair in front of the nursing station, with a soft self release velcro belt in place. Interview on September 9, 2013, at 3:45 p.m., with the Director of Nursing (DON), in the DON's office confirmed the resident was unable to self release the soft belt restraint. Interview on September 11, 2013, at 9:15 a.m., with the DON, in the conference room confirmed the restraint assessment was not completed on	F 221	assessment. At each restraint reduction assessment beginning 9/13/13, a physical therapist will complete a therapy screen on the resident for the appropriateness of the restraint and an attempt to reduce the restraint. Beginning 9/13/13, all current residents and future residents with restraints will have a quarterly restraint reduction assessment from the initial date of the initiation of the restraint, and quarterly thereafter. This will be completed by the MDS nurse and monitored by the falls IDT (DON, ADON, Therapy, Social Services, MDS nurses) 3) Beginning 9/13/13, inservice education will be given to the Physical Therapists and MDS nurses by the Director of Nursing regarding Reduction Assessments. 4) Effective 9/13/13, visual and written audits will be completed quarterly by the charge nurses/MDS nurses. The completed audits will be reported to the DON and the Quality Improvement Team by the ADON quarterly beginning 10/10/13 and will continue for six months or more if deemed necessary by the QI team.	

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F 221	Continued From page 2 August 18, 2013, the resident scored as a good candidate for attempted reduction of the restraint on August 18, 2013, and no attempt to reduce the restraint had been completed.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the call light was within reach for one resident (#58) of thirty residents reviewed. The findings included: Resident #58 was admitted to the facility on March 8, 2013, and readmitted on August 8, 2013, with diagnoses including Intestinal Obstruction, Hypertension, Diabetes, Scleroderma, Rheumatoid Arthritis, and Hypokalemia. Medical record review of the admission Minimum Data Set dated August 15, 2013, revealed the resident scored fourteen on the Brief Interview for Mental Status (BIMS) indicating the resident was independent with daily decision making and was able to be understood, and understood others.	F 246	F246 1) On 9/9/2013, call light was immediately placed within reach for resident #58. 2) On 10/4/2013, upon change of shift, in addition to every two hour routine rounds all CNA's, RN's, and LPN's will ensure that each call light is placed properly within residents reach. 3) Staff Inservice Education will be provided by the Charge Nurse on 10/3/2013 and ongoing to all facility employees. (All LPN's, RN's, CNA's, therapists, Enviromental Services, Dietary, Quality of Life, Business Office, Ilasons, and the Director of Plant Operations). ADON or designee will continue to complete weekly random visual audits on up to 20 residents weekly beginning 9/30/2013. 4) On 10/10/2013, the ADON will report findings to the Administrator and the QI team.	10/17/2013

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F 246	Continued From page 3 Observation and interview with the resident on September 9, 2013, at 2:10 p.m., revealed the resident seated in a wheelchair on the left side of the bed and the call light was wrapped around the assist bar on the right side of the bed. Interview with the resident at the time of the observation revealed the resident needed the call light to ask for assistance with transfers. Continued interview revealed the resident had previously asked the staff to ensure the call light was within reach. Observation and interview with Licensed Practical Nurse (LPN) #2 on September 9, 2013, at 2:15 p.m., confirmed the resident's call light was not within the resident's reach.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	F279 1) The comprehensive care plan of Resident #118 was updated immediately to reflect current resident's status on 9/13/13. 2) Ten medical records will be randomly audited weekly by the MDS nurses to ensure accuracy of the care plans beginning 9/30/13. 3) Staff Inservice Education will be given by the MDS nurses to RN's, LPN's, Social Service Social Workers, Director of nutritional services, Director of Quality of Life, and Director of Therapy Services on comprehensive care plan documentation on or by 9/30/13. Care plans will be updated by interdisciplinary staff members (MDS nurses RN's, LPN's, Social Services, Director of Nutritional services, Director of Quality of Life, and	10/17/2013

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F 279	Continued From page 4 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for one (#118) of thirty residents reviewed. The findings included: Resident #118 was admitted to the facility on June 5, 2012, with diagnoses including Dementia, Diabetes, and Chronic Renal Failure. Medical record review of the Psychotropic Medical Management Progress Note dated July 25, 2013, revealed "...Long and short term memory impaired, chronic (scored 5 on a scale with 10 indicating the most severe impairment); Recall impaired, chronic with a score of 5; Attention and Judgement impaired; and Appetite - Decreased with a score of 7, Acute..." Record review of the Monthly Weight Record revealed a weight of 137 pounds in March 2013 and 124 pounds in August 2013 with the weight decreasing each month. Review revealed the September weight of 123 pounds represented a 10% weight loss over the previous six months. Review of the Certified Dietary Manager (CDM) Dietary Notes for May 8, 2013, revealed "...Weight showing a trending down x (for) 90 days." Review of the CDM's Dietary Notes dated August 9, 2013, revealed "Recommendation placed in MD (doctor) communication book for Megace for increased appetite due to poor intake	F 279	Director of Therapy Services) and monitored by the MDS nurses. 4) On 10/10/13, the MDS nurses and charge nurses will report findings to nursing management team (DON, ADON, Admission nurse, Charge Nurses, Wound Care Coordinator). ADON or designee will report to the Administrator and the Quality Improvement Team monthly beginning 10/10/2013 and will continue for six months or more if deemed necessary by the QI team.	

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F 279	Continued From page 5 and weight decline..." Review of the resident's Care Plan Meeting held on August 7, 2013, revealed the family "...concerned...weight. Noted Ensure seems to give (resident) diarrhea." Review of the Care Plan approaches to address the Problem/Need of a Therapeutic Diet on admission in June 2012 revealed "Offer foods high in protein, Praise resident's attempts to follow diet, and Provide calculated diabetic diet, including snack." Review of the Care Plan dated May 8, 2013, at the annual review after the resident had been identified with significant weight loss revealed no approaches were developed to address the weight loss. Review of the quarterly Care Plan update of August 8, 2013, revealed no new approaches to address the continued weight loss. Review revealed an approach was added on August 23, 2013. "Add to assist to feed at meals." Observation and interview of the resident on September 10, 2013, at 8:45 a.m., revealed the resident was unable to recall any information about what was served or eaten for breakfast. Interview on September 11, 2013, at 8:10 a.m., with the CDM at the third floor nursing station, confirmed Ensure (a protein supplement) was not included in the care plan, although the resident had received at intervals and the family stated it caused diarrhea; an alternative to Ensure had not been added to the Care Plan during the previous month after the Ensure was stopped;	F 279		

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F 279	Continued From page 6 and dementia prevented the resident from knowingly increasing their protein intake as planned for in the CDM's May 2013 Dietary Notes "...Will encourage increased intake of protein..." Observation of the resident on September 11, 2013, at 8:25 a.m., revealed the resident was resting in bed and breakfast had not been served. Continued observation revealed the resident had a breakfast tray taken to their room at 9:15 a.m. Interview on September 11, 2013, at 10:10 a.m., with the Certified Nursing Assistant (CNA #4) revealed "...usually in bed for breakfast...if you wake up too early gets upset and won't eat anything...will usually take cereal with help...took cereal today." Interview on September 11, 2013, at 12:25 p.m., with CNA #2 revealed "(the resident) went to the bathroom...does that a lot after begins to eat..." Observation on September 11, 2013, at 12:35 p.m., revealed the resident ambulated from the bathroom to the foyer area of the nursing unit and set down. Observation revealed the nursing staff redirected the resident back to the dining room to eat lunch and LPN #1 began cueing the resident to eat. Interview by telephone on September 11, 2013, at 2:15 p.m., with the Registered Dietician (RD), confirmed the RD did not attend or contribute to the care plan meetings. Interview with the Director of Nurse's (DON), in the DON's office at 4:55 p.m., on September 10, 2013, confirmed neither the RD or Registered Nurses (RN) attended the annual or quarterly	F 279		

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F 279	Continued From page 7 care plan meetings for the resident in 2013. Interview with the DON, in the DON's office at 3:40 p.m., on September 11, 2013, confirmed the resident's Care Plan did not include the following: where the resident desired to take meals; a protein supplement; or the approach verbally shared by both the DON and the CDM related to finger foods and sandwiches being most appropriate for the resident. Interview confirmed the resident did not have a comprehensive care plan to address the weight loss.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide adequate grooming assistance for one resident (#64) of thirty residents reviewed. The findings included: Resident #64 was admitted to the facility on August 9, 2012, with diagnoses including Unstageable Pressure Ulcer of Left Heel and Coccyx, Dementia, Parkinson's Disease, recent history of Failure to Thrive following Right Hip Surgery, Chronic Back and Neck Pain, Spinal	F 312	F312 1) On 9/9/2013 resident #64 was immediately shaven, showered, nails clipped and groomed and glasses cleaned. 2) Beginning 10/1/2013, all residents will be monitored daily by the staff RN/LPN's for grooming needs. 3) Beginning 10/3/2013, staff inservice education will be given by the DON or designee to all facility personnel. (All LPN's, RN's, CNA's, therapists, Environmental Services, Dietary, Quality of Life, Business Office) ADON or designee will continue the process of weekly audits of all residents for the completion of the residents daily care beginning 9/30/2013. 4) On 10/10/2013, the Director of Nursing or the Assistant Director of Nursing will report findings to the Administrator and the QI team for 6 months or more if deemed necessary for compliance issues.	10/17/2013

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F 312	Continued From page 8 Kyphosis, Chronic Pain Syndrome, and Chronic Renal Failure related to Obstructive Benign Prostatic Hypertrophy. Record review of the Care Plan revealed under the problem of "...decreased functional status...approaches...Nail care done weekly...Assist with dressing...grooming as needed." Observation and interview with the resident on September 9, 2013, at 12:10 p.m., in the resident's room revealed the resident remained in the bed, had a beard, and dirt under long fingernails on each hand. Observation revealed the resident's glasses were on the bedside table and the lenses were visibly dirty. Continued interview revealed the resident stated "shaving was done on shower days." Interview with the Certified Nursing Assistant (CNA #3) on September 9, 2013, at 12:30 p.m., after the CNA prepared the lunch tray for the resident (who remained in the bed) and began to exit the room confirmed the resident "usually wore glasses during the day" and confirmed they were dirty and had not been cleaned or provided for the resident. Interview with the Interim Charge Nurse at the third floor nursing station on September 11, 2013, at 9:30 a.m., confirmed the resident required assistance with all activities of daily living, had a beard on Monday, September 9, 2013, and on that day the Charge Nurse had requested (the resident) be shaved. Interview confirmed residents "should be shaved even on days they are not showered." Continued interview confirmed the resident had long fingernails and	F 312		

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F 312	Continued From page 9 dirt under the nails of both hands. Interview confirmed the expectation for assistance with daily care needs included nail care and shaving if needed.	F 312		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to prevent weight loss for two residents (#118, #79) of thirty residents reviewed for weight loss. The findings included: Resident #118 was admitted to the facility on June 5, 2012, with diagnoses including Dementia, Diabetes, and Chronic Renal Failure. Record review of the Monthly Weight Record revealed a weight of 137 pounds in March 2013. Review of the Certified Dietary Manager's (CDM) Dietary Notes dated May 8, 2013, revealed	F 325	F325 1. As of 09/11/2013 for resident #118, an order was written for Beneprotein 3 times daily for 21 days, resident's weight is to be monitored weekly times 4 weeks or more if necessary. Registered dietitian assessed resident on 9/23/2013 and agreed with the current MD interventions. Resident #79 received new orders for health shake 2 times daily for increased caloric/protein intake. Registered dietitian assessed resident on 9/23/2013 with interventions as follows: Double starch added with meals, Nepro shake discontinued related to resident excercising her right to refuse the shake. 2. All residents will be identified for significant weight changes through a program that tabulates the amount of days per the percentage of weight change per the resident weight in pounds. Weights will be monitored weekly by the Director of Dietary Services effective 9/30/2013. 3. The systematic changes put into place as of 10/1/2013 include the purchase a new scale. Every resident will be weighed and weights will be documented in the weight change comparison	10/17/2013

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F 325	Continued From page 10 "...Weight showing a trending down x (for) 90 days." Medical record review of the Psychotropic Medical Management Progress Note dated July 25, 2013, revealed "...Long and short term memory impaired, chronic (scored 5 on a scale with 10 indicating the most severe impairment); Recall impaired, chronic with a score of 5; Attention and Judgement impaired; and Appetite - Decreased with a score of 7, Acute..." Review of the resident's Care Plan Meeting held on August 7, 2013, revealed the family "...concerned...weight. Noted Ensure (liquid dietary supplement) seems to give (resident) diarrhea." Review of the CDM's Dietary Notes dated August 9, 2013, revealed "Recommendation placed in MD (doctor) communication book for Megace (medication) for increased appetite due to poor intake and weight decline..." Record review of the Monthly Weight Record revealed the resident weighed 124 pounds in August 2013. Continued review revealed the September weight was 123 pounds. Observation and interview of the resident on September 10, 2013, at 8:45 a.m., revealed the resident was unable to recall any information about what was served or eaten for breakfast. Interview with the Director of Nurse's (DON), in the DON's office at 4:55 p.m., on September 10, 2013, confirmed the resident had experienced significant weight loss. Interview confirmed the Registered Dietitian (RD) had not provided	F 325	program. The registered dietitian along with the NAR IDT (DON, ADON, Charge Nurse, Wound Nurse, Social Services, MDS Nurse, Speech Therapy) were notified of new scale purchase. New Registered Dietitian contract obtained. Frequency of RD visits increased. RD will be given a copy of the weight change comparison each visit by the Director of Dietary Services as of 9/30/2013. Director of Dietary Services will also supply the RD with a list of at risk residents for assessment upon each visit. A call will be made to the RD by the Director of Dietary Services for urgent needs. An RD recommendation will be completed from the verbal communication by the Director of Dietary Services for any new interventions and given to the practitioner for approval. "Significant weight change" policy created and reviewed per the RD and Practioner and implemented as of 10/10/2013. 4. Random audits to be done by the RD monthly as of 10/10/2013. reported results will be given to the Director of Dietary services as of 10/10/2013. Director of Dietary services to report to the Administrator and QI team monthly for one year or more if deemed necessary by the QI team.	

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	445006	A. BUILDING _____ B. WING _____	09/11/2013

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ST BARNABAS NURSING HOME	950 SISKIN DRIVE CHATTANOOGA, TN 37403

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F 325	Continued From page 11 evaluation or input on the resident's weight loss. Continued interview confirmed the resident's labwork results on May 9, 2013, revealed two nutritional indicators, total protein and albumin, had below normal values at 5.8 (range 6.0 - 8.5) and 3.2 (range 3.5 - 5.0). Interview confirmed the resident did not have a protein supplement prescribed by the physician after the nutritional indicators were identified as below normal. Interview included a review of the Physician's Progress note dated August 12, 2013, and confirmed the progress note stated "trial appetite stimulant and monitor response" and confirmed the trial of an appetite stimulant had not been initiated as of September 10, 2013. Continued interview confirmed the Nursing staff had noted the resident frequently had difficulty focusing on a meal and would get up and "wander off." Interview revealed the resident had been added to "the feeder list" and was to be assisted at meals since August 23, 2013. Observation of the resident on September 11, 2013, at 8:25 a.m., revealed the resident was resting in bed and breakfast had not been served. Continued observation revealed the resident had a breakfast tray taken to their room at 9:15 a.m. Interview on September 11, 2013, at 10:10 a.m., with the Certified Nurse Aide (CNA #1) revealed, "...usually in bed for breakfast...if you wake up too early gets upset and won't eat anything...will usually take cereal with help, but won't eat much else at breakfast...took cereal today." Observation on September 11, 2013, at 12:25 p.m., revealed the resident was not in the dining room eating. Continued observation revealed the resident exited their room and ambulated to the	F 325		

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F 325	Continued From page 12 foyer area of the nursing unit. Observation revealed the nursing staff redirected the resident back to the dining room to eat lunch. Observation revealed the resident began to eat slowly and alone at a table with no feeding assistance. Interview with the RD by telephone on September 11, 2013, at 2:15 p.m., confirmed the RD had not been asked to review the resident for weight loss from March 2013 to the present and was unaware of the resident's weight loss. Interview with the Director of Nurse's (DON), in the DON's office at 4:00 p.m., on September 11, 2013, confirmed the following: the resident did not have any additional labwork checked since May 2013, the DON had not been able to locate any evaluation by the RD that defined the resident's Ideal Body Weight range, and the Nutritional at Risk committee reviewed the Monthly Weight Record for all the resident's, but had not identified the resident's monthly decline in weight prior to August 23, 2013. Resident #79 was admitted to the facility on August 28, 2012, with diagnoses including Dysphagia, Acute Respiratory Failure, and Renal Failure. Medical record review of the Departmental Notes dated May 3, 2013, revealed "...wt (weight) 135 (pounds) had a recent diet change receives Puree meat with soft veggies..." Review of the weight record revealed the resident's weight was 133 pounds on June 3, 2013, and 120 pounds on September 2, 2013, (10 percent weight loss in 3 months)	F 325		

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F 325	Continued From page 13 Medical record review of the Dietitian's Recommendations dated May 31, 2013, revealed "...recommendation...Nepro 1 can po (by mouth) bid (twice a day) between meals..." Medical record review of the physician's progress note dated June 11, 2013, revealed "...dietary noncompliance-pt. (patient) eats what...wants (and) refuses what...doesn't want..." Medical record review of a Physician's order dated June 17, 2013, revealed "...D/C (discontinue) shake (with) meals...begin Nepro 1 can BID between meals..." Medical record review of the Medication Record dated June 17, 2013, revealed the Nepro 1 can bid was implemented on June 17, 2013. (seventeen days after the dietary recommendation) Medical record review of the Departmental Notes dated July 13, 2013, revealed "...Poor diet, Ensure offered and taken well..." Medical record review of the Departmental Notes dated August 1, 2013, revealed "...wt. 125 (pounds)...continues to receive Puree Meat with soft vegetables diet as ordered...Weight down 4 (pounds) x 90 days due to reduction in doughnuts and sweets family would bring to facility. Family has stopped bringing these items, intake of meals 80 (percent)..." Medical record review of the Departmental Notes dated August 23, 2013, revealed "...NAR (nutrition at risk) weight trending down will provide shake tid (three times a day) with meals. Weekly weight..."	F 325		

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F 325	Continued From page 14 Review of the NAR meeting minutes dated August 30, 2013, revealed "...Family not providing as many snacks..." Observation on September 11, 2013, at 8:50 a.m., revealed the resident sitting on the bed eating breakfast, consisting of oatmeal, eggs, yogurt, milk, and mighty shake with a staff member sitting next to the resident to offer the resident encouragement to eat. Interview with the Registered Dietitian (RD) on September 11, 2013, at 1:20 p.m., by telephone confirmed the RD was not aware of the resident's continued weight loss and would have increased the nepro to three or four times a day. Interview with the Certified Dietary Manager (CDM) on September 11, 2013, at 3:00 p.m., in the conference room, confirmed a delay in starting the RD recommendation for the Nepro 1 can BID.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, observation, and interview, the facility failed to ensure a physician's order for fluid restriction was being maintained for one (#13) of thirty sampled residents.	F 327	F327 1) On 9/11/2013, the water pitcher for resident #13 was removed promptly from resident's room. LPN #1 and CNA #1 were reeducated in regards to a fluid restriction order and the standards for maintaining the order. A door identifier was placed on the residents door by the DON. A call was placed to the practitioner in regards to the amount of fluid intake by the Charge Nurse. As of 10/3/2013, a newly amended policy was given to all RN/LPN's, CNA's, Dietary staff, Social Services, Quality of Life staff, and	10/17/2013

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F 327	Continued From page 15 The findings included: Resident #13 was admitted to the facility on June 13, 2012, with diagnoses including Chronic Kidney Disease, End Stage Renal Disease, Diabetes, and Congestive Heart Failure. Medical record review of a Physician's order dated October 10, 2012, revealed "1500 ml (milliliters) fluid restriction per day." Medical record review of the Care Plan revealed, "10/10/12 Fluid restriction 1500 ml/day." Medical record review of Dietary notes revealed no documentation of the breakdown of fluids to be provided by dietary and or nursing for the the resident each shift. Review of facility policy, Restricted Fluids, revealed "...1. Licensed Nurse will note the Physician's order in regard to fluid restriction and develop and/or follow a plan for the amount of fluids to be consumed by the resident each shift...3. The resident with an order for restricted fluids will not have a water pitcher or cup at the bedside, with measured amounts of fluids to be included in total...4. The resident that is receiving restricted fluids will be identified by: a. A door identifier will be placed on the resident's door to identify resident's on fluid restriction...8. If the resident is not consuming the amount of fluid ordered (under or over the amount ordered), the Licensed Nurse will notify the physician and document further orders." Observation of the resident's room, on September 11, 2013, at 10:05 a.m., revealed a	F 327	Therapy staff regarding restricted fluids. 2) Revisions were made to the facility policy titled "Restricted Fluids". The policy will reflect the following: a) Beginning 10/1/2013, RN/LPN'S will document the amount of daily fluid restriction on a newly created form titled "Fluid Restriction Log" to be maintained monthly with in the Medication Administration Record and kept as a part of the residents permanent medical record. b) All residents will be given education in regards to fluid restrictions. When the resident verbalizes an understanding of fluid restrictions they will be allowed to keep a graduated pitcher in the room at the bedside with the measured amount of fluid to be included in the total fluid intake by the RN/LPN. c) The resident that is receiving restricted fluids will be identified with a visual reminder posted within the resident room. This will display the amount of restriction. d) The RN/LPN will notify the practitioner when restricted amount is over the ordered fluid restriction. 3) ADON or designee will do weekly audits of all fluid restriction logs and report findings to the Nurse Management Team (DON, ADON, Charge Nurse, Wound	

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F 327	Continued From page 16 water pitcher at bedside and no door identifier to indicate the resident was on restricted fluids. Interview on September 11, 2013, at 10:10 a.m., with the Certified Nursing Assistant (CNA #1) providing the resident's care revealed CNA #1 was unaware of how much fluid the resident was allowed per shift. Interview Licensed Practical Nurse (LPN #1) on September 11, 2013, at 10:15 a.m., in the 200 hallway revealed LPN #1 was unaware of the breakdown of fluid to be given by dietary and nursing. Further interview revealed LPN #1 was unaware how many milliliters the resident was allowed each shift. Interview with the Dietary Manager on September 11, 2013, at 11:00 a.m., in the Director of Nursing's (DON) office revealed the resident is on a "select diet" which means the resident chooses liquids to be provided by dietary for each meal. Further interview confirmed in a twenty-four hour period no more than 960 ml was to be provided by dietary for the resident. Interview with the DON in the DON's office on September 11, 2013, at 2:40 p.m., confirmed the facility's Restricted Fluids policy had not been followed for developing a plan for the amount of fluids to be provided by dietary and nursing. Further interview confirmed the resident was not to have a water pitcher at bedside and a fluid restriction identifier had not been placed on the resident's door.	F 327	care Nurse, Admissions Nurse, MDS nurse. 4) The ADON will report findings to the Administrator and the QI team for 6 months or more if deemed necessary for compliance issues.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332	F332 1) On 9/16/13 nurse # 3 and nurse #4 were reissued a copy of the medication administration	10/17/2013

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F 332	Continued From page 17 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a five percent or less medication error rate in 4 of 32 opportunities observed. The findings included: Medical record review of the Physician's orders dated September 1, 2013 through September 30, 2013, for resident #119 revealed "...Keppra (anti-seizure medication) 250 mg (milligram) tablet Take 1 tab by mouth twice daily...Aspirin EC (enteric coated) take 1 tab by mouth every day..." Observation with Licensed Practical Nurse (LPN) #3 of a medication pass for resident #119 on September 10, 2013, at 8:00 a.m., revealed LPN #3 omitted Keppra 250 mg and Aspirin 81 mg. Medical record review of the Physician's orders for resident #4 dated September 1, 2013 through September 30, 2013, revealed "...Vitamin D (D3) 1000 IU (International units) cap take 1 by mouth every day...Prilosec (gastric acid pump inhibitor) (20 mg) take 1 cap by mouth every day..." Observation with LPN #4 of a medication pass for resident #4, on September 10, 2013, at 8:40 a.m., revealed LPN #4 administered Vitamin D 400 IU and omitted Prilosec 20 mg.	F 332	policy. Nurse #3 and nurse #4 will be tested on the knowledge of this policy on 9/26/2013. Starting 9/26/13, the ADON or designee will do a random medication administration with Nurses #3 and 4, to assure the accuracy of the medication administration. 2) On 10/3/2013, the consultant pharmacist will in service every RN/LPN in regards to medication administration for accuracy. Effective 10/1/2013, upon new hire and bi-annually, each nurse will complete a medication administration in service and will be tested on the medication administration policy. 3) Beginning 10/1/2013, a monthly visual audit will be completed by the ADON or designee. This audit will select 2 nurses per week at random for medication administration observation. The consultant pharmacy technician will continue to observe nurses monthly for accuracy of medication administration. 4) The ADON and Charge nurse will report findings to the Director of Nursing on a weekly basis. The monthly visual audits will be reported by the ADON ton the DON and QI team beginning 10/10/2013 and will continue for 6 months or as deemed necessary.	

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F 332	Continued From page 18 Interview with LPN #3 on September 10, 2013 at 8:20 a.m., in the hall confirmed the Keppra and Aspirin had not been administered to resident #119. Interview with LPN #4 on September 10, 2013, at 8:45 a.m., in the hall confirmed vitamin D 400 IU was administered to resident #4 and the Prilosec had not been administered.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431 1) On 9/11/2013, Nurse #1 was reeducated by the Director of Nursing in regards to all medications being in a locked compartment. Policy reissued to nurse #1. This will be followed up with testing of the knowledge of the policy. 2) As of 10/3/2013, the consultant pharmacist will in service all RN/LPN's in regards to medication administration and securing medications. 3) Beginning 10/1/2013, a monthly visual audit will be completed by the ADON or designee for unsecured medications. This audit will select 2 nurses per week at random for the understanding and/or demonstration of the knowledge of proper security storage of all medications. 4) The ADON will report findings to the Administrator and the QI team for 6 months or more if deemed necessary for compliance issues.	10/17/2013

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F 431	Continued From page 19 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were secured on one of five medication carts. The findings included: Observation on September 11, 2013, at 8:57 a.m., revealed an unattended medication cart in the hallway outside of room 225. Further observation revealed a plastic cup containing approximately 60 ml. (milliliters) of a watery mixture. Continued observation revealed the cart remained unattended for three minutes until the nurse returned. Interview with Licensed Practical Nurse #1 at that time revealed the cup contained a Carafate tablet mixed in water. Continued interview confirmed the medication had been left unsecured for a period of time and had not been properly stored.	F 431		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced	F 502	F502 1) For resident #22, lab work was immediately obtained by Memorial lab on 9/11/2013 and results were placed on the chart. 2) Beginning on 10/4/2013, orders written for lab work will be documented on lab work log to ensure that services are accurate and timely. On 9/31/2013, all orders will be reviewed per the	10/17/2013

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F 502	Continued From page 20 by: Based on medical record review and interview, the facility failed to ensure a laboratory test was completed for one resident (#22) of thirty residents reviewed. The findings included: Resident #22 was admitted to the facility on July 25, 2012, with diagnoses including Encephalopathy, Congestive Heart Failure, and Dementia. Medical record review of a Physician's order dated September 2, 2013, revealed "...TSH (Thyroid Stimulating Hormone) every six months. First draw to be done 9-2-13..." Medical record review revealed no laboratory report for the TSH level on September 2, 2013. Interview with Licensed Practical Nurse #5 on September 11, 2013, at 8:30 a.m., at the nursing station confirmed the TSH level had not been obtained.	F 502	charge nurse for accuracy. As of 9/30/2013, outpatient lab will continue to retrieve lab specimens and transport labs/cultures to the laboratory. 3) As of 9/30/2013, the lab work log will be maintained daily by the unit secretary. Results will be retrieved and logged per the unit clerk. The unit clerk will separate the lab results and distribute to each RN/LPN. The RN's/LPN's will review, initial the lab work, and place the lab work results in practitioner's communication book or call practitioner based on results as well. All quarterly lab work will be obtained on the same scheduled dates for the entire facility. All annual lab work will also be obtained on the same scheduled dates for the entire facility. As of 9/30/2013 the lab work log will be audited weekly by the charge nurses for completion of the lab collection process. The findings will be reported to the Director of Nursing or the Assistant Director of Nursing. 4) Effective 10/1/2013, lab process will be audited by the charge nurse and reported weekly in the nursing management meeting (DON, ADON, MDS nurses, Charge nurses, Wound Care Coordinator, Admissions Coordinator. DON or designee will evaluate weekly occurrences and report them to the QI team beginning 10/10/2013 for 6 months or more if deemed necessary for compliance issues.	